

01 Health Assessment

Record everyone applying for coverage on this page. List each household member, then complete the health questions and current medications. Accurate answers drive correct quoting and underwriting.

HOUSEHOLD MEMBERS

NAME	DATE OF BIRTH	AGE	HEIGHT	WEIGHT

HEALTH QUESTIONNAIRE

Mark Yes or No for each applicant. If Yes, note details in the space provided.

In the past 12 months, has the applicant used any form of tobacco? ☐ YES ☐ NO

Has the applicant tested positive for HIV, or been diagnosed by a physician with AIDS or a life expectancy of 12 months or less? ☐ YES ☐ NO

Is the applicant currently bedridden, hospitalized, in a care facility, or receiving hospice care? ☐ YES ☐ NO

Does the applicant receive assistance with daily living activities such as taking medications, bathing, toileting, dressing, or eating? ☐ YES ☐ NO

Has the applicant ever been diagnosed with, treated by a doctor, or taken medication for any of the following conditions?

Disease of the heart, including heart attack, heart surgery, or congestive heart failure? ☐ YES ☐ NO

Disease of the circulatory system, including stroke, aneurysm, seizure, lupus, sickle cell anemia, or advised to have surgery to improve circulation? ☐ YES ☐ NO

Cancer, other than basal cell skin cancer? ☐ YES ☐ NO

Disease of the lungs, including COPD, chronic asthma, or use of oxygen, nebulizers, or nitroglycerin? ☐ YES ☐ NO

Disease of the liver or kidney, including insulin-dependent diabetes, Hepatitis B or C, or an organ transplant? ☐ YES ☐ NO

Complications of diabetes such as amputation, diabetic coma, blindness, neuropathy, or kidney disorder? ☐ YES ☐ NO

In the past 12 months, has the applicant been confined to a hospital more than twice, or had any surgeries? ☐ YES ☐ NO

If yes, when, how many times, and what for? _____

Recommended for counseling for alcohol or drug abuse, convicted of a DUI or felony, or on parole? ☐ YES ☐ NO

If yes, how recently? _____

Depression, bipolar disorder, schizophrenia, or memory loss including Alzheimer's, dementia, or ALS (Lou Gehrig's disease)? ☐ YES ☐ NO

CURRENT MEDICATIONS

02 Present the Options

Present the coverage options to the client. Fill in the death benefit and premium for each, then check the box on the option the client chooses to move forward with.

PERMANENT LIFE — Permanent coverage that protects you your whole life

- ✓ Premiums never increase and benefits never decrease
- ✓ Protected from the very first day the policy is in effect
- ✓ Policy never expires or cancels while premiums are paid
- ✓ Coverage cannot be cancelled due to age or health changes
- ✓ Benefits pay out within 24–72 hours upon claim approval
- ✓ Includes living benefits depending on carrier & qualifications

COVERAGE QUOTE • FINAL EXPENSE

OPTION 1 ☐	OPTION 2 ☐	OPTION 3 ☐
DEATH BENEFIT \$ _____ MONTHLY PREMIUM \$ _____	DEATH BENEFIT \$ _____ MONTHLY PREMIUM \$ _____	DEATH BENEFIT \$ _____ MONTHLY PREMIUM \$ _____

RIDERS ☐ Accelerated Death Benefit ☐ Accidental Death Benefit \$ _____

03 Pre-Application Sheet

* REQUIRED FIELD

Complete the beneficiary, proposed insured, and owner details needed to begin underwriting. Fill in every field before calling the carrier verification line or e-app. Keep this secured; do not submit this form.

BENEFICIARY(IES)

☐ Primary ☐ Contingent % OF PROCEEDS _____

FULL NAME

DOB

RELATIONSHIP TO INSURED

PHONE

SSN

☐ Primary ☐ Contingent % OF PROCEEDS _____

FULL NAME

DOB

RELATIONSHIP TO INSURED

PHONE

SSN

PROPOSED INSURED

FULL NAME *

DATE OF BIRTH *

PRESENT AGE

SEX *

☐ M ☐ F

HEIGHT *

WEIGHT *

STATE / COUNTRY OF BIRTH *

HOME ADDRESS (STREET, CITY, STATE, ZIP) *

HOME PHONE

CELL PHONE *

EMAIL *

SSN *

DRIVER'S LICENSE / STATE ID # *

DL STATE *

PHYSICIAN NAME

CITY, STATE, ZIP

OWNER

Complete only if different from proposed insured

FULL NAME OF POLICY OWNER

DATE OF BIRTH

PRESENT AGE

SEX

☐ M ☐ F

RELATIONSHIP TO INSURED

STATE / COUNTRY OF BIRTH

HOME ADDRESS (STREET, CITY, STATE, ZIP)

HOME PHONE

CELL PHONE

EMAIL

SSN

DRIVER'S LICENSE / STATE ID #

DL STATE

04 Plan & Payment Info

* REQUIRED FIELD

Lock in the policy details: company, plan, premium, payment method, and any replacement coverage. Confirm each figure with the client before submitting the application.

PLAN & PAYMENT INFO

INSURANCE COMPANY NAME

POLICY TYPE

☐ Whole Life ☐ Term Life ☐ Index Universal Life (IUL) ☐ Annuity ☐ Guarantee Issue (GI)

PLAN TYPE

☐ Level (Preferred) ☐ Level (Standard) ☐ Graded ☐ Modified

TERM LENGTH

☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 years

COVERAGE AMOUNT APPLIED FOR *

\$

PREMIUM AMOUNT *

\$

AD&D RIDER

☐ Yes ☐ No

NAME AS IT APPEARS ON ACCOUNT

ACCOUNT TYPE *

☐ Checking ☐ Savings

NAME OF FINANCIAL INSTITUTION *

ROUTING # *

ACCOUNT # *

INITIAL PREMIUM PAYMENT * (SELECT ONE)

☐ Deduct immediately upon approval / issue ☐ Deduct on or after _____

ONGOING MONTHLY AUTO PAYMENT (SELECT ONE)

☐ Specific day (1-28) ☐ Week (1-4) ☐ Weekday (M-F)

REPLACEMENT

If applicable

Do they have current or pending insurance with this or any other company?

☐ YES ☐ NO

Is the insurance applied for intended to replace or change any current coverage?

☐ YES ☐ NO

INSURER NAME		POLICY #
1		
2		
3		

05 Emergency Contacts

According to the National Unclaimed Property Network, roughly **20% of all life insurance policies become lost** and are turned over to State Unclaimed Property Departments, because surviving family members never knew the policies existed. Millions of dollars in life insurance go unclaimed every year.

As an added service, we will reach out to your emergency contacts, provide them with our contact information and a business card, and answer any questions. When the time comes, your family will not be alone — they will know exactly who to call so your policy never goes unclaimed.

EMERGENCY CONTACTS

NAME ADDRESS PHONE RELATIONSHIP	NAME ADDRESS PHONE RELATIONSHIP
NAME ADDRESS PHONE RELATIONSHIP	NAME ADDRESS PHONE RELATIONSHIP
NAME ADDRESS PHONE RELATIONSHIP	NAME ADDRESS PHONE RELATIONSHIP